R590. Insurance, Administration.
R590-259. Dependent Coverage to Age 26. (*Effective 6-27-2011*)
R590-259-1. Authority.

This rule is promulgated by the insurance commissioner pursuant to Subsections 31A-2-201(3), 31A-2-212(5) and 31A-22-605(4).

R590-259-2. Purpose and Scope.

(1) The purpose of this rule is to clarify marketplace rules relating to the coverage of children in the individual and group health benefit plan markets that have experienced disruption arising from implementation of federal health care reform.

(2)(a) Except as provided in R590-259-2(2)(b), this rule applies to any health insurer that provides individual or group health benefit plan coverage.

(b) Subject to R590-259-7, this rule applies to grandfathered plan coverage for individual and group health benefit plan coverage.

R590-259-3. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purposes of this rule.

(1) "Certificate of insurability" means a certificate issued to an individual by the Utah Comprehensive Health Insurance Pool, pursuant to Subsection 31A-29-111(5)(c).

(2) "Grandfathered plan coverage" means coverage provided by a health insurer in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

(3) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(4) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, ERISA, to the extent that the plan provides medical care, as defined in R590-259-3(10), and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(5)(a) "Health benefit plan" means a policy, contract, certificate or agreement offered by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(b) "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(c) "Health benefit plan" does not include:

(i) coverage only for accident, or disability income insurance, or any combination thereof;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics; and

(viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(d) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(e) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance.

(f) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

(iii) similar supplemental coverage added to coverage under a group health plan.

(6) "Health insurer" means an insurer that offers a health benefit plan.

(7) "Individual carrier" has the same meaning as defined in Section 31A-30-103.

(8)(a) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.

(b) For purposes of this subsection, a health insurer offering health insurance coverage in connection with a group health plan shall not be deemed to be a health insurer offering individual health insurance coverage solely because the insurer offers a conversion policy.

(9) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(10) "Medical care" means amounts paid for:

(a) the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure

or function of the body;

(b) transportation primarily for and essential to medical care referred to in R590-259-3(10)(a); and

(c) insurance covering medical care referred to in R590-259-3(10)(a) and (b).

(11) "Participant" adopts the meaning given under section 3(7) of ERISA.

(12) "Subscriber" means, in the case of individual health insurance contract, the person in whose name the contract is issued.

R590-259-4. Eligibility for Dependent Coverage to Age 26; Definition of Dependent; Uniformity of Plan Terms.

(1) A health insurer that makes available dependent coverage of children shall make that coverage available for children until attainment of 26 years of age.

(2) With respect to a child who has not attained 26 years of age, a health insurer shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant, and, in the individual market, primary subscriber.

(3) A health insurer shall not deny or restrict coverage for a child who has not attained 26 years of age:

(a) based on the presence or absence of the child's financial dependency upon the participant, primary subscriber or any other person, residency with the participant and in the individual market the primary subscriber, or with any other person, student status, employment or any combination of those factors; or

(b) based on eligibility for other coverage, except as provided in R590-259-7.

(4) Nothing in this rule shall be construed to require a health insurer to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the adoptive parent of that grandchild.

(5) The terms of coverage in a health benefit plan offered by a health insurer providing dependent coverage of children cannot vary based on age except for children who are 26 years of age or older.

R590-259-5. Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status - Applicability; Opportunity to Enroll; Written Notice; Effective Date.

(1) This section applies to any child:

(a) whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the attainment of 26 years of age; and

(b) who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 by reason of the provisions of this section.

(2)(a) If group health insurance coverage or individual health insurance coverage, in which a child described in R590-259-5(1) is

eligible to enroll, or is required to become eligible to enroll, in the coverage in which the child's coverage ended or did not begin for the reasons described in R590-259-5(1), and if the health insurer is subject to the requirements of this section the health insurer shall give the child an opportunity to enroll that continues for at least 30 days.

(b) The health insurer shall provide the opportunity to enroll, including the written notice beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(3)(a) The notice of opportunity to enroll shall include a statement that children whose coverage ended, or who were denied coverage, or were not eligible for coverage, because the availability of dependent coverage of children ended before the attainment of 26 years of age are eligible to enroll in the coverage.

(b)(i) The notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.

(ii) For group health insurance coverage:

(A) the notice may be included with other enrollment materials that the health insurer distributes to employees, provided the statement is prominent; and

(B) if a notice satisfying the requirements of this section is provided to an employee whose child is entitled to an enrollment opportunity under R590-259-5(2), the obligation to provide the notice of enrollment opportunity under R590-259-5(3) with respect to that child is satisfied.

(c) The written notice shall be provided beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.

(4) For an individual who enrolls under R590-259-5(2), the coverage shall take effect not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

R590-259-6. Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status - Group Health Plan Special Enrollee.

(1) A child enrolling in group health insurance coverage pursuant to R590-259-5 shall be treated as if the child were a special enrollee, as provided under 45 CFR Section 146.117(d).

(2)(a) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(b) For purposes of this subsection, any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(3) The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

R590-259-7. Grandfathered Group Health Plans - Applicability.

(1) For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(2) For plan years, beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan shall comply with the requirements of R590-259-4 through 6.

R590-259-8. Enrollment Periods.

(1) An individual carrier shall offer:

(a) continuously enrollment for individuals applying for a new policy unless R590-259-9 applies; and

(b) for a dependent to be added to an existing policy:

(i) beginning May 1, 2011 and extending through June 15, 2011 for coverage effective July 1, 2011; and

(ii) at least once a year beginning 45 days prior to the policy renewal; or

(iii) continuously.

(2) During an enrollment period in R590-259-8(1), a dependent under the age of 19 shall be offered coverage on a guaranteed issue basis and without any limitations, pre-existing exclusions or riders based on health status.

(3) A health insurer shall provide prior written notice to each of its policyholders annually of the enrollment rights in R590-259-8(1)(b) that includes information as to the enrollment dates and how a dependent eligible for enrollment may apply for coverage with the insurer.

R590-259-9. Utah Alternative Mechanism Enrollment.

(1) An individual carrier shall only be required to offer coverage to an individual under age 19 if the individual first obtains a certificate of insurability from the Utah Comprehensive Health Insurance Pool pursuant to Subsection 31A-30-108(3) and 31A-30-109(1), in which case, the coverage shall be offered by the carrier:

(a) on a continuous open enrollment basis; and

(b) on an underwritten basis without any limitations, pre-existing exclusions or riders based on health status.

(2) An individual carrier shall not:

(a) require a health benefit plan offered under the requirements of this section to cover more than one individual;

(b) deny or unreasonably delay the issuance of a policy; or

(c) refuse to issue a policy.

R590-259-10. Special Enrollment for Qualifying Events.

Nothing in this rule shall alter an applicant's ability to obtain health insurance during a special enrollment period, outside of the open enrollment period, resulting from a qualifying event as defined

by the Health Insurance Portability and Accountability Act.

R590-259-11. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

R590-259-12. Enforcement Date.

The department will begin enforcing the provisions of this rule immediately.

R590-259-13. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

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